

Chart #: _____

Pediatric Associates of Franklin

570 Bakers Bridge Avenue, Franklin, TN 37067

AUTHORIZATION FORM: RELEASE OF **SPECIFIC ITEMS** FROM THE MEDICAL RECORD

As parent or legal guardian of the following child, I hereby authorize Pediatric Associates of Franklin to release to me the following information from my child's medical record. I authorize that this specific information be released regarding my child's physical or mental condition. I also understand that this release is only for the items mentioned on this form and that if the entire medical record is to be released or transferred that a separate medical record's release is required.

Please circle all that apply:

Sports Physical Form

Other (Please attach form)

Vaccine Administration Record (Parent's Copy)

(Sports Forms can't be faxed but are available through our Secure Patient Portal on the Website)

Tennessee Department of Health Certificate of Immunization

(Used for Schools and Day Care)

Check Your Child's Provider:

___ Meneely ___ Brooks ___ Chambers ___ Carr ___ Townsend ___ Couden ___ Hood ___ Peabody ___ Copeland

Please Complete the Following:

Child's Name: _____ Date of Birth: _____

Parent or Legal Guardian's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Parent's Signature (or Patient's if 18 or older): _____

Date: _____ Telephone Number where you can best be reached: _____

Please Indicate Preference: (Mailed record takes up to 48 hours)

_____ Mail (**Complete self addressed envelope**)

_____ Fax to: _____ (**Sports Forms Excluded**)

_____ Pick up (**Takes 48 hours for processing**)

Processed & Documented in Chart By: _____ Date: _____